TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
SENTRY INSURANCE A MUTUAL COMPANY

MFDR Tracking Number
M4-17-2638-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 8, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The request for the services was performed by Cheryl Paradis at Coventry, the Carrier's review department. It was the Carrier's preauthorization department that deemed the services 'medically necessary'. To deny payment for the reason of 'treatment(s)/service(s) is medically unreasonable/unnecessary' does not seem valid."

Amount in Dispute: $945.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Note that one reason for denial is that 'the claim is in dispute'. There is also a peer review basis for denial the addresses medical necessity."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 22, 2016 through January 12, 2017	90837 X 7	$945.00	$945.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §137.100 outlines the disability management treatment guidelines.
4. 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 283 – Based on a peer review, payment is denied because the treatment(s) service(s) is medically unreasonable/unnecessary.
   - 216 – Based on the findings of a review organization

Issue(s)

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor submit documentation to support that CPT Code(s) 90837 rendered on September 22, 2016 through January 12, 2017 were preauthorized?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier's position summary states in pertinent part, "Note that one reason for denial is that 'the claim is in dispute'." The Division reviewed the EOBs presented by the parties in this dispute and finds that the defense raised in the insurance carrier's position summary was not a denial defense identified on the EOBs contained in the DWC060 request, or that this defense was raised by the insurance carrier during the medical bill review process.

   28 Texas Administrative Code §133.307(d)(2)(F) states that " The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent did not submit sufficient information to MFDR to support that the new defense raised on the position summary had ever been presented to the requestor or that the requestor had otherwise been informed of the new denial reason or defense prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The requestor seeks reimbursement for CPT codes 90837 rendered on September 22, 2016 through January 12, 2017. The insurance carrier denied the disputed services with denial reason codes "283 – Based on a peer review, payment is denied because the treatment(s) service(s) is medically unreasonable/unnecessary" and "216 – Based on the findings of a review organization."

   28 Texas Administrative Code §137.100 states in pertinent part," (e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Review of the preauthorization letters issued by Coventry authorizing the disputed services, states the following:

   Preauthorization letter dated August 19, 2016

Service Description	Quantity	Dates of Requested Service
Individual/psychotherapy x 6 visits 90837	6 per diem	08/19/16 – 10/31/16

   Preauthorization letter dated November 10, 2016

Service Description	Quantity	Dates of Requested Service
Individual/psychotherapy x 6 visits 90837	6 per diem	11/10/16 – 01/13/17

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the disputed CPT Code 90837 rendered September 22, 2016 through January 12, 2017 were provided within the preauthorization timeframes indicated above. As a result, the insurance carrier's denial reasons are not supported. As a result, the requestor is entitled to reimbursement for the disputed services.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 90837, service date September 22, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.47 multiplied by the PE GPCI of 0.92 is 0.4324. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.822 is 0.09042. The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Procedure code 90837, service date September 29, 2016, represents a professional service with reimbursement determined per §134.203(c). The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended. Therefore this amount is recommended.

   Procedure code 90837, service date October 13, 2016, represents a professional service with reimbursement determined per §134.203(c). The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Procedure code 90837, service date October 20, 2016, represents a professional service with reimbursement determined per §134.203(c). The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Procedure code 90837, service date December 6, 2016, represents a professional service with reimbursement determined per §134.203(c). The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Procedure code 90837, service date December 27, 2016, represents a professional service with reimbursement determined per §134.203(c). The sum of 3.52282 is multiplied by the Division conversion factor of $56.82 for a MAR of $200.17. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Procedure code 90837, service date January 12, 2017, represents a professional service with reimbursement determined per §134.203(c). Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $135.00. Therefore this amount is recommended.

   Review of the submitted documentation finds that the requestor is entitled to $945.00 for disputed CPT Code 90837 rendered September 22, 2016 through January 12, 2017.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $945.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $945.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.